AMERICAN UNIVERSITY
Student Health Center

OFFICE of CAMPUS LIFE

DOCUMENTATION OF PREVIOUS ADHD TREATMENT

Providers, please fill out the form below so that this student may continue treatment at AU SHC. **Please include a copy of chart notes and any information regarding recent prescriptions.** Please submit the completed form and accompanying notes back to our office.

- Email: **shc@american.edu**
- Fax: **(202) 885-1222**
- Mailing address:

American University
Student Health Center
4400 Massachusetts Avenue, NW
McCabe Hall
Washington, DC

Students Name:_____Date of Birth_____

Providers Name:_____Specialty_____

Name of Practice: _____

Address: _____

Telephone:_____Fax: _____

Have you ever diagnosed and treated this patient with ADHD in the past? Yes No

If yes, what are the approximate dates you have treated this patient for ADHD? _____

Which type?_____Predominate inattention____combined type____Predominate hyperactivity

How would you describe your practice?____Pediatrician__Family Practice___Psychiatry
____Psychologist Other_____

How was this diagnosis made? *(Check all that apply)*

___Psycho-educational testing

___Clinical Interview and observation

___Validated checklists by patient

_____Validated checklists via parents and/or teachers

_____Referral to Psychiatrist

_____Referral to Psychologists

_____Other _____

Please list any medication this patient is currently taking:

_____
_____
_____
_____
_____
_____

Please state if this patient was diagnosed with or treated for any other behavioral health condition:

_____
_____
_____
_____
_____
_____

Please list any other medical conditions for this patient:

_____
_____
_____
_____
_____

Do you have any concerns about this patient misusing stimulants or other substances?_____NO_____YES

If yes, please explain:

_____
_____
_____
_____

Name of Provider:_____

Signature_____**Date**_____

****This form MUST accompany copy of notes and prescription history to be considered complete**